Facility: ____
North Carolina Division of State Operated Healthcare Facilities
Continuing Care Plan (CCP) for Community Follow-Up/Discharge Summary

Addressograph

Patient's Name: ____________________________ MRUN: ________________________

Admitting LME: __________________________________ Code: ______ County__________________

Discharge LME: __________________________________ Code: ______ County__________________

Responsible LME ________________________________ Code ______ County ________________

Outpatient Appointments: Consent Signed

Name of Place:		**Y**	**N**
Contact Person:			
Date and Time:			
Address:			
Phone Number:			
Fax Number:			
Purpose:			

Name of Place:		**Y**	**N**
Contact Person:			
Date and Time:			
Address:			
Phone Number:			
Fax Number:			
Purpose:			

Name of Place:		**Y**	**N**
Contact Person:			
Date and Time:			
Address:			
Phone Number:			
Fax Number:			
Purpose:			

☐ Check box for Homeless (per Homeless policy) **Fax copy of CCP to DSOHF at 919-508-0955:**

Give patient a completed copy of this form prior to discharge and also fax form to LME.

( ) Info faxed to LME on (Date) ________________by_____________
( ) Info faxed to All Aftercare Providers on (Date)_________________by______

CONTINUING CARE PLAN/DISCHARGE SUMMARY **Addressograph**

PART I

Please complete this form without acronyms, abbreviations or jargon; the patient should be able to fully understand content in order to follow. An interpreter for Spanish must be provided for Spanish speaking only patients.

Patient Name: _____ Date of Birth: _____/_____/_____

Admitted: _____/_____/_____ Discharged:_____/___/____ Admission # ☐ 1st ☐ 2nd ☐3rd >3 List____

Type of Insurance Benefits: ☐Medicaid ☐Medicare ☐Military/Veteran ☐Private/Other:_____

☐Check if patient identified in CCNC portal. If identified, Care Manager Name _____

Discharged to Address:_____ Ph#:(___)_____

_____

Discharged to: ☐Private Residence ☐Group Home ☐Assisted Living Facility ☐Halfway House

☐Skilled Nursing Facility ☐Homeless Shelter ☐Family Care Home ☐ Other: _____

Contact Person/Billing Address – Name_____ Relationship: _____

Address: _____ Phone #: (____)_____

Significant Other/Guardian – Name_____ Relationship: _____

Address: _____ Phone #: (____)_____

Designated Payee – Name: _____ Relationship_____

Address: _____ Phone #: (____)_____

Discharge Status: ☐Court-ordered Outpatient Commitment Expiration Date: _____/_____/_____ County _____

☐SA Outpatient Commitment Expiration Date: ____/_____/_____ County _____ ☐No Outpatient Commitment

Reason for outpatient commitment: _____

Instructions to Community Providers: How to Prevent Crisis or Calm Patient, Including Relevant Services:

_____

_____

_____

_____

_____

_____

_____

_____

_____

CONTINUING CARE PLAN/DISCHARGE SUMMARY **Addressograph**

PART II: ANTICIPATED PATIENT NEEDS AND REFERRAL LEVELS OF CARE

CONTINUING CARE PROVIDER INFORMATION

TO BE COMPLETED BY SOCIAL WORK STAFF

A. Psychosocial Needs to be Addressed: (Check all that apply)

☐ Access to Health Care	☐ Social Support	☐ Recreation
☐ Cognitive/Judgment Issues	☐ Social Services	☐ Self-Care
☐ Coping Skills	☐ Lack of Transportation	☐ Language Barrier
☐ Significant Medical Concerns	☐ Unemployment	☐ 12-Step Meetings
☐ SSI/SSDI/ Medicaid/Medicare	☐ Cultural/Spiritual	☐ Legal or Juvenile Justice System
☐ Social Skills	☐ Medication Assistance	☐ Financial Stressors
☐ Family/Marital Assistance	☐ Advance Directives	☐ Housing Needed
☐ Public Education	☐ Education Other	☐ Other: _____

Explain all items checked. Please be specific with recommendations for treatment approach for the above checked needs:

_____

_____

_____

_____

_____

_____

_____

B. Type of Service(s) Recommended: ☐ Assertive Community Treatment Team (ACTT) ☐ Community Support Team (CST)

☐ Community Support (CS) ☐ Substance Abuse Intensive Outpatient Program (SAIOP) ☐ Individual Therapy ☐ Peer Support

☐ Substance Abuse Comprehensive Outpatient Treatment (SACOT) ☐ ADATC ☐ Psychosocial Rehabilitation (PSR)

☐ Multi-systemic Therapy (MST) ☐ Intensive In-Home (IIH) ☐Group Therapy ☐ Home Health

☐ Psychiatric Residential Treatment Facility ☐ Child & Adolescent Day Treatment ☐ Family Therapy ☐ Physical Rehab

☐ Medication Management and Treatment ☐ County Resource List Provided ☐ NC Care Link Info Provided

☐ National Alliance on Mental Illness (NAMI) phone number: 800 451-9682 ☐ Vocational Rehab

☐ Targeted Case Management ☐ SSI/SSDI Outreach, Access and Recovery (SOAR)

☐ IDD Clinical Home/TCM/Care Coordinator ☐ NC START

☐Other: _____

Input into this Plan Received From ☐ Patient ☐ Family ☐ LME ☐ Hospital Treatment Team ☐ Outpatient Provider

☐ Residential Provider ☐ Other

Hospital Social Worker involved in this Discharge: _____

Signature

_____

Printed Name & Phone Number

LME On-Site Hospital Liaison Involved in this Discharge: _____

(Name and Phone Number)

CONTINUING CARE PLAN/DISCHARGE SUMMARY **Addressograph**

PART III: PATIENT RECOVERY PLAN

Name: _____

A. Completed by Social Worker:

My Emergency Contact:
Phone Number: _____ **Name:** _____

My LME Crisis Number _____

B. Completed by Client:

My strengths:

_____
_____
_____
_____

Activities and things I want to do in the community, i.e., programs, school, work, church, leisure activities, etc.:

_____
_____
_____
_____

Things that can make me upset and stressed and may lead to hospitalization:

_____
_____
_____

Things I can do to calm myself when I'm upset and stressed:

_____
_____
_____
_____

Ways friends, family, and community workers can help me when I'm upset and stressed:

_____
_____
_____
_____

CONTINUING CARE PLAN/DISCHARGE SUMMARY **Addressograph**

Part IV (pages 5 and 6) **Medical Diagnoses, Follow Up Recommendations and Education:**

Completed by Medical Provider

Medical Care Follow Up:

☐ No aftercare appointment needed.

☐ Appointment needed with ☐Primary Medical Provider in ☐ _____days/weeks/months &/or ☐as needed for med refills.

☐Specialist in _____days/weeks/months.

☐Other _____in _____ days/weeks/months.

Appointments to be arranged by **(check 1):** ☐Patient ☐Family ☐Social Worker ☐Residential Facility Staff ☐LME Staff

If PATIENT is to make Appt check one:

☐ Social Worker to provide information regarding medical resources.

☐ Patient has medical provider, needs no further resources at this time.

Diagnoses/Findings/Tests of concern: Instructions/Recommendations for Patient

☐Smoking Causes Cancer/Heart Attack/COPD/Death → **Please QUIT Smoking (NC Tobacco Use Quit Line: 1-800-784-8669)**

☐Asthma/COPD → Get a recheck with Dr in_____

☐Abnormal Cholesterols/Body Fats → Reduce fats and sweets, Get recheck with Dr. in _____
Total chol _____ LDL "bad" chol_____ HDL "good" chol _____ TG _____ ☐Exercise **OR** ☐Discuss Exercise program with your Dr.

☐Elevated Blood Pressure/Hypertension → Get a recheck with Dr. in_____

☐High Blood Sugar, Diabetes, Metabolic Syndrome → Eat a heart healthy diet/ Get a recheck with Dr. in _____

☐Coronary Artery Ds☐Abnormal EKG☐Low/High Heart Rate → Get a recheck with Dr. in _____

☐Overweight/Obese → Eat heart healthy diet/Get a recheck with Dr. in _____

☐Liver abnormality_____ ☐AST ____ ☐ALT_____ → Get a recheck with Dr. in _____

☐Abnormal Blood Count ☐Low☐High

☐Red Cells☐White Cells☐Platelets:Details_____→ Get a recheck with Dr in _____

☐GI: ☐Constipation☐GERD☐Gastritis☐IBS☐IBD → Get a recheck with Dr in _____

☐Seizure(s)/Seizure Disorder _____ → Get a recheck with Dr. in _____

☐Acute☐Chronic Pain _____ → Get a recheck with Dr. in _____

☐Abnormal Thyroid _____ → Get a recheck with Dr. in _____

☐Immunizations given: _____ → Immunizations needed: _____

☒ If you are currently ABLE to become pregnant please contact your health department/private provider for pregnancy prevention or family planning services.

☒ If you GET pregnant, see Dr. for evaluation right away.

☐You are on medication(s) that can harm a fetus. If you get pregnant consult your Dr. right away.

CONTINUING CARE PLAN/DISCHARGE SUMMARY **Addressograph**

Part IV Continued from page 5 - **Medical Diagnoses, Follow Up Recommendations and Education**
Completed by Medical Provider

DIET: ☐Regular ☐Heart Healthy/Diabetic/Calorie Controlled ☐Other Diet:_____

ALLERGIES: Food, Contact - List _____

ALLERGIES: Medication - List _____

Other Medical Diagnoses and Follow Up/Treatment:

☒ **Take all Medications as prescribed and recommended.** ☒ **Take this document to your Medical Provider at your next visit.**

The information and instructions contained on pages 5 and 6 of this Continuing Care Plan have been explained to me. I acknowledge that I understand the instructions and that a copy of the instructions has been provided to me. I agree to follow the instructions.

Medical Provider Signature for pages 5 and 6:	**Print:**	**Date/Time:**
Signature of staff member giving instructions:	**Print:**	**Date/Time:**
Patient/ Legally Responsible Person Signature:	**Print:**	**Date/Time:**

CONTINUING CARE PLAN/DISCHARGE SUMMARY **Addressograph**

Part V (pages 7 and 8) **ORYX Core Measures Supplemental Data/Medication Information and Instructions**

Completed by Psychiatrist

I have reviewed the Medication Reconciliation form and the current patient medication list to determine the following medications:

Antipsychotic Medications Prescribed at Discharge (check all that apply):

- □ Aripiprazole (Abilify®)
- □ Asenapine (Saphris®)
- □ Chlorpromazine (Thorazine®)
- □ Clozapine (Clozaril®, FazaClo®)
- □ Fluphenazine (Permitil®, Prolixin®)
- □ Haloperidol (Haldol®)
- □ Iloperidone (Fanapt®)
- □ Loxapine (Loxitane®)
- □ Lurasidone (Latuda®)
- □ Mesoridazine (Serentil®)
- □ Molindone (Moban®)
- □ Olanzapine (Zyprexa®, Zyprexa Zydis®)
- □ Olanzapine + Fluoxetine (Symbyax®)
- □ Paliperidone (Invega®)
- □ Perphenazine (Trilafon®)
- □ Pimozide (Orap®)
- □ Quetiapine (Seroquel®)
- □ Risperidone (Risperdal®, Risperdal Consta®, Risperdal M-Tab®)
- □ Thioridazine (Mellaril®)
- □ Thiothixene (Navane®)
- □ Trifluoperazine (Stelazine®)

Rationale for prescribing 2 or more antipsychotic medications (Check One):

□ History of minimum of 3 or more failed trials of monotherapy. List 3 failed medications:

(1)_____

(2)_____

(3)_____

□ Recommended plan to taper to monotherapy or tapering in process (cross taper)

Medication being decreased:

_____

Medication being increased (if applicable)

_____

□ Augmentation of Clozapine

□ Other - Specify and explain below:

_____

_____

_____

Cognitive Impairment (entire hospital stay):

□ Yes □ No □ Unknown

Comfort Care:

□ Day 0 or 1 □ Day 2 or After

□ Not Documented/Unknown

□ Not on Comfort Measures

□ Timing Unclear

Reason for Admission: _____

(Print legibly. No abbreviations-All diagnoses must be included.)

Final Principal Diagnosis: _____

Other Discharge Diagnoses:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Axis V: GAF at Admission: _____ GAF at D/C: _____

CONTINUING CARE PLAN/DISCHARGE SUMMARY **Addressograph**

Part V Continued from page 7- **ORYX Core Measures Supplemental Data/Medication Information and Instructions**
Completed by Psychiatrist

DISCHARGE MEDICATIONS **DISCHARGE DATE**_____

DRUG ALLERGIES: ☐ None ☐ List_____

***** Please note -** due to the potential for harm, no medications brought to the hospital are being returned except as noted below. Please take medications as directed on your medication containers.

Discharge Medications ☐ **Spanish Labeling**	**Dose/ Route**	**Frequency**	**# of doses to dispense**	***** Return Pre-admission medication to patient**	**Outside Prescription**	**Indication for Medication**
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	

Patient Instructions:

☐ Follow-up with Mental Health Center/private psychiatrist
☐ Follow-up with Medical Provider
☐ Follow all recommendations
☐ If your condition worsens, contact your After Care Provider
☐ Medication Education Provided
☐ Other: _____

Psychiatrist Signature for pages 7 and 8:	**Print:**	**Date/Time:**
Co-Signature (if applicable)	**Print:**	**Date/Time:**
Signature of staff member giving instructions:	**Print:**	**Date/Time:**

All the instructions contained in this Continuing Care Plan have been explained to me. I acknowledge that I understand and will follow these instructions. A copy of this continuing Care Plan has been given to me.

Patient/ Legally Responsible Person Signature:	**Print:**	**Date/Time:**

Facility Authorization Disclosure Forms must be completed for all needed exchanges of information.